California State Board of Pharmacy
1625 N. Market Blvd, Suite N219, Sacramento, CA 95834
Phone (916) 574-7900
Fax (916) 574-8618
www.pharmacy.ca.gov

STATE AND CONSUMERS AFFAIRS AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
ARNOLD SCHWARZENEGGER, GOVERNOR

REQUIREMENTS FOR FILING AN APPLICATION FOR STERILE COMPOUNDING PHARMACY LICENSE

(Business & Professions Code Sections 4127 and 4127.1)

The following may compound injectable sterile drug products in California: A pharmacy that is specially licensed with the board as a sterile compounding pharmacy, or a pharmacy that is operated by an entity that is licensed by the board or the State Department of Health Services and has a current accreditation from the Joint Commission on Accreditation of Healthcare Organizations or another accreditation agency approved by the board (at the current time there is no other agency).

- A license to compound injectable sterile drug products may not be issued until the location is inspected by the board and found to be in compliance with Article 7.5 of Chapter 9, of Division 2 of the Business and Professions Code and regulations adopted by the board.
- All pharmacies that compound injectable sterile drug products must follow board regulations for sterile compounding. These regulations are found in Title 16 of the California Code of Regulations as Article 8, beginning with section 1751.

For a complete application, **the following items must be submitted:**

1. A completed and signed Application for Sterile Compounding Pharmacy License (17A-48).

2. Fee of $500, made payable to “Board of Pharmacy”

3. A copy of the pharmacy's proposed policies and procedures for sterile compounding on disk, CD or hard copy. If emailing the policies and procedures, please send to CompoundingPharmacy@dca.ca.gov.

4. Corporate officer, owner, or partner who signed the application will need to complete the enclosed “Request for Live Scan Service” form.

** Effective January 1, 2001, the Board of Pharmacy requires all applicants for a new license to have not only a California Department of Justice (DOJ) criminal record check but also a federal background check. **No license will be issued without background clearances from both agencies.**

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APPLICATION FOR A STERILE COMPOUNDING PHARMACY LICENSE

Please print or type **ALL BLANKS MUST BE COMPLETED; IF NOT APPLICABLE, ENTER N/A**

Name of Pharmacy:	Pharmacy License Number
Pharmacy Telephone Number:	Sterile Compounding Telephone Number: (if different)
Address of Pharmacy: Street and Number	City State Zip Code

Name of pharmacist-in-charge of licensed pharmacy:	Pharmacist license number
Residence address: Street and Number	City State Zip Code

Indicate whether this application is for:

☐ New Licensed Sterile Compounding License ☐ Change of Location of Licensed Sterile Compounding pharmacy ☐ Change of Ownership of Licensed Sterile Compounding pharmacy

If this is a **change of ownership** or **change of location**, indicate previous name, address and license number of compounding pharmacy.

Name:	Address:	License Number:

Please indicate type of ownership:

☐ Individual ☐ Partnership ☐ Corporation ☐ Not-for-profit corporation ☐ Government owned

I certify that the policies and procedures of the sterile compounding are in compliance with California Code of Regulations Title 16, section 1751 et seq. *(A copy of the pharmacy's proposed policies and procedures for sterile compounding must accompany the application.)*

Signature of Pharmacist-in-Charge _____ Name (please print) _____ Date _____

CONTINUE ON REVERSE

FOR OFFICE USE ONLY

STAFF REVIEW		CASHIER LOG
☐ _____ ☐ _____ ☐ _____ ☐ _____ Referred for inspection: _____ Inspection Completed: _____	Approved _____ Denied _____ Date _____	Cashier # _____ Date _____ Amount of fee _____

Ownership Information

A license to compound injectable sterile drug products may only be issued to the owner of a licensed pharmacy at the licensed location.

If a Sole Ownership:				
Name of Sole Owner			*Social Security Number	Telephone Number
Address number and street		City	State	Zip Code
If a Partnership: (attach additional sheet if needed)				
Name of Partner			*FEIN Number	Telephone Number
Address number and street		City	State	Zip Code
Name of Partner			*FEIN Number	Telephone Number
Address number and street		City	State	Zip Code
If a Corporation: (attach additional sheet if needed)				
Name of Corporation (If applicable)				Telephone Number
Address number and street		City	State	Zip Code

Print below the name, title, address and license number of all the pharmacy owners. This includes the individual owner, all partners, corporate officers. Under the heading "Licensed as" list any state professional or vocational licenses held; e.g., pharmacist, physician, podiatrist, dentist or veterinarian etc., and license number. Non-profit organizations must list the names and titles of persons holding corporate positions. Attach additional sheets if necessary.

Title	Name	Residence Address	Social Security Number	Licensed as and license number

*Disclosure of your social security number (or federal employer identification number ("FEIN"), if you are a partnership) is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42 USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number or FEIN will be used exclusively for tax enforcement purposes or compliance with any judgment or order for family support in accordance with section 17520 of the Family Code. If you fail to disclose your social security number or your FEIN, your application for initial or renewal license will not be processed AND you may be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

*Federal Employer Identification Number

PLEASE READ CAREFULLY

This application must be approved by the California State Board of Pharmacy before a Sterile Compounding License will be issued.

If changes are made during the application process, you may need to submit a new application with the appropriate fees. **Any application not completed within 60 days after you have been notified by the board of deficiencies in your file, may be deemed to have been abandoned, and you may be required to file a new application and meet all the requirements which are in effect at the time of application. Fees applied to this application are not transferable and are not refundable.**

Any material misrepresentation in the answer of any question is grounds for refusal or subsequent revocation of a license, and is a violation of the Penal Code of California. All items of information requested in this application are mandatory. Failure to provide any of the requested information will result in the application being rejected as incomplete.

The information will be used to determine qualifications for licensure under California Pharmacy Law. The officer responsible for information maintenance is the Executive Officer, (916) 445-5014, 400 R Street, Suite 4070, Sacramento, California 95814. The information may be transferred to another governmental agency (such as a law enforcement agency) if necessary for it to perform its duties. Each individual has the right to review the files or records maintained on him/her by the Board of Pharmacy, unless the records are identified as confidential information and exempted from disclosure by the California Information Practices Act. (Civil Code §1798, et seq.)

Signature Block

Under penalty of perjury, under the laws of the State of California, I certify and affirm that: (1) I am a person authorized to act for and bind the applicant and I am at least 18 years of age; (2) I have read the foregoing application and know the contents thereof and each and every statement made therein is true; (3) I understand that falsification of any information I this application may constitute grounds for denial or subsequent revocation of the license; (4) no person other than the applicant [or applicants] has any direct or indirect interest in the applicant's [or applicants'] business to be conducted under the license for which this application is made; and (5) all supplemental statements filed with this application are true, complete and accurate.

Signature of Person Authorized to Submit Application	Name (please print)	Title	Date

Mail all correspondence to the following address below. If correspondence should be mailed to the pharmacy please insert "Same as Pharmacy."	
Name and telephone number of contact person to clarify information provided on this application. ( )	e-mail address

INSTRUCTIONS FOR COMPLETING A "REQUEST FOR LIVE SCAN SERVICE" FORM
(California Residents)

The following instructions are provided to assist you in completing this form accurately. Please follow all instructions carefully and print clearly; failure to do so may result in processing delays of your application.

1. **Job Title or Type of License, Certification, or Permit:** Enter the type of license, certification or permit for which you are applying. Appropriate license types include pharmacist, pharmacy technician, intern pharmacist, exemptee, or if an owner or officer of a pharmacy, hospital, clinic, wholesaler or hypodermic permit enter appropriate title of the facility.
2. **Name of Applicant:** Enter your last name, first name and middle name. Do not use initials or name abbreviations.
3. **AKA:** Enter all other names you have used, including your maiden name.
4. **CDL No:** Your California Driver's License Number.
5. **DOB:** Your date of birth (month/day/year).
6. **SEX:** Your gender (male or female).
7. **HT:** Your height in feet and inches.
8. **WT:** Your weight in pounds.
9. **Misc. No.:** Enter other identifying numbers. (e.g., Other State Driver's License Number)
10. **EYE Color:** Color of your eyes
11. **HAIR Color:** Color of your hair
12. **Home Address:** Your residence address
13. **POB:** Enter your place of birth.
14. **SOC:** Enter your Social Security Number

Take the completed form to your nearest Live Scan site for fingerprint scanning. There are more than 130 Live Scan sites throughout the state. An up-to-date Live Scan site list is on the Department of Justice's (DOJ) Internet web page at http://ag.ca.gov/fingerprints/publications/contact.htm or call your local police or sheriff's department.

Contact the live scan service for hours of operation, an appointment (if necessary), acceptable forms of payment and identification requirements. Be prepared to pay **ALL applicable fees** (DOJ processing fee of $32, FBI processing fee of $24, and fingerprint scanning service fee) at the time your prints are taken. The live scan fingerprinting service fee varies from about $5 to $20. The cost to electronically submit your fingerprints is determined by the local Live Scan agency and the agency can charge a fee sufficient to recover its costs.

The lower portion of the Request for Live Scan Service form must be completed by the live scan operator. The original of the form is retained by the scanning service; the second copy is to be attached to your application and submitted to the board; and the third copy is for your records.

FINGERPRINTING AUTHORITY

Section 144(b) of the Business and Professions Code authorizes the Board of Pharmacy to require an applicant for licensure to furnish a full set of fingerprints for purposes of conducting criminal history record checks. Fingerprints are required in order for the DOJ/FBI to conduct background checks for criminal convictions.

REQUEST FOR LIVE SCAN SERVICE

Applicant Submission

ORI: A0071 (Code assigned by DOJ) Type of Application: (check one) ☐ Employment ☑ License, Certification, Permit ☐ Volunteer

Job Title or Type of License, Certification or Permit: Pharmacy - Section 4201

(See instruction sheet for appropriate license types)

Agency Address Set Contributing Agency:

Board of Pharmacy
Agency authorized to receive criminal history information

05712
Mail Code (five-digit code assigned by DOJ)

1625 N. Market Blvd, Suite N219
Street No. Street or PO Box

Licensing
Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834
City State Zip Code

(916) 574-7900
Contact Telephone No.

Name of Applicant: _____
(Please print) Last First Middle

AKA's: _____
Last First

CDL No. _____
California Driver's License Number

DOB: _____ SEX: ☐ Male ☐ Female
Date of Birth

Misc. No. **BIL -** Applicant Must Pay Fees
Agency Billing Number (if applicable)

HT: _____ WT: _____
Height Weight

Misc. No. _____
Other State Driver's License Number

EYE Color: _____ HAIR Color: _____

Home Address:

POB: _____
Place of Birth

Street or PO Box

SOC: _____
Social Security Number

City, State and Zip Code

Your Number: N/A
OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☑

If resubmission, list Original ATI No. _____

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A
Employer Name

N/A
Street No. Street or PO Box

N/A
Mail Code (five digit code assigned by DOJ)

N/A
City State Zip Code

N/A
( )
Agency Telephone No. (Optional)

Live Scan Transaction Completed By: _____ Date _____
Name of Operator

Transmitting Agency ATI No. Amount Collected/Billed

BCII 016 (rV 10/98) ORIGINAL **-Live Scan Operator; SECOND COPY-Board of Pharmacy; THIRD COPY-Applicant**

REQUEST FOR LIVE SCAN SERVICE

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Job Title or Type of License, Certification or Permit: Pharmacy - Section 4201

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Agency Address Set Contributing Agency:

Board of Pharmacy — Agency authorized to receive criminal history information

05712 — Mail Code (five-digit code assigned by DOJ)

1625 N. Market Blvd, Suite N219 — Street No. Street or PO Box

Licensing — Contact Name (Mandatory for all school submissions)

Sacramento, CA 95834 — City State Zip Code

(916) 574-7900 — Contact Telephone No.

Name of Applicant: (Please print) Last First Middle

AKA's: Last First

CDL No. — California Driver's License Number

DOB: — Date of Birth

SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay Fees — Agency Billing Number (if applicable)

HT: — Height

WT: — Weight

Misc. No. — Other State Driver's License Number

EYE Color: HAIR Color:

Home Address:

POB: — Place of Birth

Street or PO Box

SOC: — Social Security Number

City, State and Zip Code

Your Number: N/A — OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☑

If resubmission, list Original ATI No.

Employer: (Additional response for Department of Social Services, DMV/CHP licensing, and Department of Corporations submissions only)

N/A — Employer Name

N/A — Street No. Street or PO Box

N/A — Mail Code (five digit code assigned by DOJ)

N/A — City State Zip Code

( ) N/A — Agency Telephone No. (Optional)

Live Scan Transaction Completed By: — Name of Operator

Date

Transmitting Agency

ATI No.

Amount Collected/Billed

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Applicant Submission

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AKA's: Last First

CDL No. — California Driver's License Number

DOB: — Date of Birth

SEX: ☐ Male ☐ Female

Misc. No. **BIL -** Applicant Must Pay Fees — Agency Billing Number (if applicable)

HT: — Height

WT: — Weight

Misc. No. — Other State Driver's License Number

EYE Color: HAIR Color:

Home Address:

POB: — Place of Birth

Street or PO Box

SOC: — Social Security Number

City, State and Zip Code

Your Number: N/A — OCA No. (Agency Identifying No.)

Level of Service DOJ ☑ FBI ☑

If resubmission, list Original ATI No.

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Date

Transmitting Agency

ATI No.

Amount Collected/Billed